JOINT MPH PROGRAM

UNIVERSITY OF GONDER AND

ADDIS CONTINENTAL INSTITUTE OF PUBIC HEALTH

ASSESSEMENT OF HIV RISK BEHAVIOR KNOWLEDGE AMONG WOLAYTA SODDO PREPARATORY SCHOOL STUDENTS IN SNNPR WOLAYTA ZONE, ETHIOPIA

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A THESIS SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF GONDAR, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS IN PUBLIC HEALTH

JUNE, 2011

ADDIS ABABA

ETHIOPIA

ACKNOWLEDGEMENT

I would like to thank UoG and all the staff of ACIPH, Library and Computer lab. I would also like to pass my appreciation to all of the instructors at which study school for all the support they gave to me to accomplish this thesis.

My deepest gratitude goes to my respectful first and second advisors Dr. Gizachew Abdeta and Dr. Alemayehu Worku for their all round resourceful, unreserved, support throughout my study period and to the completion of this thesis.

I would like to extend my deepest gratitude to Dr.Romeo Bachand and his family for fully sponsoring my study and the thesis research work.

I would like to extend my great appreciation to the study team, to all study participants, and Zonal, woreda and participating schools for their meaningful cooperation during fieldwork.

I would like to pass my heart-felt gratitude to my friend W/ro Tigist Mamo for giving me fruitful suggestions, comments and unreserved support throughout the study period.

Finally, I am greatly indebted to my family, relatives and friends who gave me courage deserve my utmost gratitude for helping me to do the research work

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ACRONYMS and ABBRIVATIONS

ABC Abstinence, Be faith full, Condom use

AIDS Acquired Immiuno-Deficiency Syndrome

BSS Behavioral Surveillance Survey

CDC Center for Disease Control

CI Confidence Interval

CSW Commercial Sex Workers

DHS Demographic and Health Survey

EDHS Ethiopia Demographic and Health Survey

HIV Human Immiuno Virus

KABP Knowledge-Attitude-Behavior-Practice

MOH Ministry of Health

OR Odds Ratio

SNNPR Southern Nations Nationalities and Peoples Region

STDS Sexually Transmitted Diseases

STIs Sexually Transmitted Infections

UNAIDS United Nations Program on HIV/AIDS

VCT Voluntary Counseling and Testing

WHO World Health Organization

YRBS Youth Risk Behavioral Survey

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ABSTRUCT

Statements of the problem: More than half of all new HIV infections occur in 15 to 24 year-olds. Members of this age group feel less susceptible to adverse outcomes associated with risk behaviors and are therefore, at greater risk for HIV/AIDS. Lack of awareness and misconceptions by the young people about HIV/AIDS risk behavior might have contributed to the spread of the disease. The knowledge of HIV risk behavior of wolayta soddo preparatory school students has not been studied so, this study aimed to assess the level of awareness about HIV infection risk behavior among Wolayta Soddo Preparatory School students.

Objective: is to assess the HIV risk behavior knowledge among Wolayta Soddo Preparatory School students

Methods: A cross-sectional descriptive study was undertaken by using a pre-tested self administering questionnaire for a total of 363 respondents from Jan, 10 to18, 2011 to assess the level of knowledge of HIV /AIDs risk behavior among Wolayta Soddo Preparatory School students.

Results: The total number of students who responded to the questionnaire was 351 giving a response rate of 96.6%. Out of the total respondents, there were 141 (40.2%) female and 210 (59.8%) male students. Most of the students 87% were in the range of 15-19 years of age. The mean age of the study subjects was 15.5 years with the median age of 15 years. Nearly 53.6% of respondents mentioned correct answer for HIV risk behavior related questions. Males were found to be 1.65 times more knowledgeable than females (OR =1.653, 95% CI (1.075, 2.542). 29.9% of the study subjects reported that they had experienced sexual intercourse. Out of this number, 77.1% were males and 22.9% were females. The mean age of sexual onset is 16.7 ($\pm$1.73) years for males and 16years for females. Of the sexually active study participants 11.4% of the respondents had reported that they had 2-3 life time partners and 8.6% had more than 4, and among male respondents who had engaged in sexual relationships 14.3% had experienced it with commercial sex workers.

Conclusion and Recommendation: Even though the study found that knowledge of HIV risk behavior was encouraging, but generally was not satisfactory enough to sustain adequate HIV/AIDS response in a context of high and widespread HIV/AIDS prevalence, Upgrading the capacity of school clubs, peers, teachers help to disseminate accurate information were recommended.

INTRODUCTION

Without a cure now its third decade, acquired immunodeficiency syndrome (AIDS) is a cause of serious public health concern in the world. Estimates indicated that over 40 million people worldwide are infected with human immunodeficiency virus (HIV), the cause of AIDS. More than half of all new HIV infections occur in 15 to 24 year-olds. Members of this age group generally feel less susceptible to adverse outcomes associated with risk behaviors and are, therefore, at greater risk for HIV/AIDS. Furthermore, high-risk behaviors established in youth often extend into adulthood, making intervention at a younger age imperative to prevent chronic risk behaviors (1).

Sub-Saharan Africa is more heavily affected by HIV and AIDS than any other region of the world. An estimated 22.5 million people are living with HIV in the region - around two thirds of the global total. Young people, from age 15–24 account for 45% of all new HIV infections in adult (UNAIDS, 2008). In 2009 around 1.3 million people died from AIDS in sub-Saharan Africa and 1.8 million people became infected with HIV. The social and economic consequences of the AIDS epidemic are widely felt, not only in the health sector but also in education, industry, agriculture, transport, human resources and the economy in general. The AIDS epidemic in sub-Saharan Africa continues to devastate communities, rolling back decades of development progress (2).

In Ethiopia HIV/AIDS is a major public health problem. Moderately recent report estimated that a total numbers of people living with HIV infection are 1,037,267 in the year 2008 with the prevalence of 2.2% (female 2.6 % vs. male 1.8 %) and (Urban 7.7 % vs. rural 0.9 %). Of all people living with HIV /AIDS in this country, it was estimated that young people within the age

group 15-24years had the highest prevalence of 5.6% .This has an overwhelming effect on the socio-economic development of the country(3,4,5,6). Lack of awareness and misconceptions by the public about HIV/AIDS risk behavior might have contributed to the spread of the disease. In addition, lack of access to information, education and counseling about the disease also contribute to continued high-risk behaviors. To date, the only protection against infection with the disease is to modify behavior pattern in order to minimize risk. Hence, information dissemination, education and communication continue to play a major role in the prevention of HIV/AIDS (7,8).

In several other countries, the magnitude of the problem is very high among young adults associated with risky behaviors. Studies suggested that determining the magnitude of HIV infection and assessing behavioral risk factors of its transmission and prevention among the various segments of the population in Ethiopia are scarce.

Study had been conducted in different high school students in Ethiopia indicated that students who were involved in unprotected sex with multiple casual partners do not recognize that they are at risk of HIV infection. Another study among secondary school students showed that one third (33.3%) of the youth reported to have had sexual intercourse. Mean age of sexual initiation was 15.3 year. Study indicates that the mean number of sexual partners within six months was around two to ten. (9.3%) had sex with commercial sex workers with in that period of the months. Adolescence and risk taking often seem to be closely related. Since teenagers frequently have a sense of invulnerability, they may put themselves at great risk without really understanding what it means. (10, 11, 12)

Based on the statistical evidence HIV /AIDS has become the irresistible national crisis in all its aspect, affecting economic and developmental resources of the country (HAPCO, 2004)

according to CDC's Youth Risk Behavioral Survey (YRBS), many young people begin having sexual intercourse at early ages: 47% of high school students have had sexual intercourse, and 7.4% of them reported first sexual intercourse before age 13 and this predispose them at risk for HIV infections (CDC, 2004).

RATIONALE OF THE STUDY

Although the sexual risk behaviors of high school students are addressed to such extent, the knowledge of HIV risk behavior of wolayta soddo preparatory school students has not been studied. Assessing the awareness of the problem among this group gives some clue about the potential impact of the problem and is useful to design effective preventive intervention for the future hopes of educated working forces of the county. Therefore, the aim of this study is to explore the level of awareness about HIV infection risk behavior among wolayta Soddo preparatory school students.

LITERATURE REVIEW

Reviewed studies conducted on HIV/AIDS risk behavior knowledge among Chinese high school students revealed that Students answered all HIV transmission questions correctly. However, there is still room for improvement. First of all, it is the uneven knowledge in the subcategories of mode of transmission, prevention and general knowledge. As high as 40.3% students still believed mosquitoes are vectors of HIV and 24 (9.3%) thought sharing public swimming pools with infected people were risky. Small number of students knew that HIV could be transmitted through oral sex with HIV infected people. Most students had no idea about ABC Prevention method (13, 14).

In other similar studies most of the respondents were aware that condom use during sexual intercourse is an essential component of both HIV/AIDS prevention as well as prevention of other sexually transmitted disease, whereas the rate of wearing condom among students having sexual intercourse each time was still low. Therefore, it will be important in future HIV prevention campaigns to focus not only on HIV knowledge but also on developing and maintaining safe sexual behavior. Most were also aware that HIV was transmitted by the sharing of needles by drug users, receiving blood from an infected person, and from mother-to-child transmission (15, 16).

Several other studies reviewed and showed that almost all the students had heard of HIV/AIDS, On the other hand, only half of the respondents answered that there are differences between HIV and AIDS, indicating a lower level of deeper knowledge. The respondents were good at giving the correct answers to the routes of HIV transmission, 'sexual intercourse without a condom' and 'sharing needles for injecting drugs'. These are also the most important routes of transmission for

the general population to be aware of. They found it more difficult to exclude incorrect route. Daily domestic contacts were usually excluded, but kissing and sexual intercourse with a condom were often considered as routes of transmission. These misconceptions may increase the stigmatization of HIV positive people, as was shown in a study in San Francisco, California where students with misconceptions about transmission of HIV through casual contact were more likely to answer that students with AIDS should not be allowed to attend school (17, 18, and 19).

Reviewed studies conducted on HIV/AIDS knowledge among South African Secondary School Students 14-35 years and found that young people are very aware that AIDS is a disease that is sexually transmitted and fatal. They were less knowledgeable about HIV and how it is physically transmitted from one person to another, the asymptomatic carrier phase and methods for preventing HIV infection. The studies showed moderate to high levels of misconceptions about the risk of contracting HIV from casual contact with a person with HIV or AIDS, such as sharing clothes, toilet seats and eating utensils, coming into contact with saliva from coughing or spitting, dry kissing and from insect bites(20).

There are also several groups of adolescent people with increased vulnerability for HIV transmission because of their social status. Among the growing number of street children or street girls, the risk of infection is exacerbated due to a high prevalence of risky sexual behaviors and injecting drug use. Although the growing public awareness of the existence of the HIV crisis, the actual knowledge of the problem is superficial, particularly among adolescents. Their understanding of the modes of transmission and prevention methods is incomplete and often misconstrued (21).

Recent research in North region's three districts in Bangladesh by jointly Rainbow Nari OShishu Kallyan Foundation has shown that while provide HIV information with discussions of safe-sex and gender issue may be discouraged for young girls and women because of the ordinary belief that to inform them about sexuality and safe-sex is to encourage sexual activity. Even though that for fear of encouraging sexual activity, mothers deny imperative information about sexual-live, safe sex, reproductive health information from their daughters (22).

Several study revealed that a large proportion of young people are not concerned about becoming infected with HIV. Young people need accurate, age-appropriate information about HIV infection and AIDS, including how to talk with their parents or other trusted adults about HIV and AIDS, how to reduce or eliminate risk factors, how to talk with a potential partner about risk factors, where to get tested for HIV, how to use a condom properly. Information should also include the concept that abstinence is the only safest and effective way to avoid infection (Leigh BC et al, 1993)

CDC study has shown that early, clear parent-child communication regarding values and expectations about sex is an important step in helping young people to delay sexual initiation and make responsible decisions about sexual behaviors later in their lives (23, 24). Parents are in a unique position to engage their children in conversations about HIV and STD, because the conversations can be ongoing and timely (Dittus P, 2004). Schools also can be important partners for reaching young people before high-risk behaviors are established, as evidenced by the YRBS (CDC, 2004).

The sexuality situation in Ethiopia is the same as other African countries. study conducted by the family guidance association of Ethiopia on adolescent sexuality revealed that 71.9% of boys and

71.4% girls have had their first sexual contact in the age range of 15-17 years .the 2005 Ethiopian DHS also found out that the median age for first sexual intercourse was 16.3 years. The respondents initiated sex as early as 11 years. Some of the reasons for sexual debut were identified, such as maintaining relation with male partners (51%), for the sake of passionate love (45.6%), and to overcome loneliness (40%) (25 26 27, and 28).

According to one study conducted in Bale Zone of Oromiya Regional National state on factors that influence school adolescence exposure to HIV/STDS majority of the students (98.0%) were aware of HIV /AIDS and (88.9%) of them had heard of diseases that can be transmitted through sexual intercourse. They have mentioned sexual intercourse (86%) and contaminated infection needles (66.o%)as major modes of HIV transmission while mosquito bite (27.7%) and eating uncooked chicken that had swallowed used condom (37.9%) were the major misconceptions reported.(29)

As reviewed from study conducted in Gondar high school students, even though the majority of the students had adequate knowledge about HIV/AIDS and VCT, their perception of risk of acquisition and practice of protected sex is low. These call for continued and strengthened health education to bring behavioral changes among the students (29).

OBJECTIVES

General objective

To assess level of knowledge of HIV risk behavior among Wolayta Soddo Preparatory School Students

Specific objectives

- To assess the level of awareness of risky sexual behavior for HIV infection among Wolayta Soddo Preparatory School students.

METHODOLOGY

STUDY AREA and PERIOD

This study was carried out among Wolayta Soddo Preparatory School students, South West Ethiopia from Jan, 10 to Jan, 18 2011 for one week period. **Soddo** is a town in south-central Ethiopia. The administrative center of the Wolayta Zone of the Southern Nations, Nationalities, and Peoples Region, Soddo has a latitude and longitude of 6°54′N 37°45′E6.9°N 37.75°E with an elevation between 1600 and 2100 meters above sea level, respectively and is considered to be "woinadega" by its climate. It is also the administrative center of Soddo Zuria woreda and has 5 sub cities. Based on figures from the Central Statistical Agency in 2008, this town has an estimated total population of 65,737 of whom 34,069 are men and 31,668 are women. The total number of younger population in the town is estimated to be 16, 434, when 25% of the total population is considered as young people. It is 370 km far from Addis Ababa. There is one governmental preparatory school in the town and there were about 26 sections of preparatory students and each section contains about 90 students. The total number of students was about 2340.of which 1340 were females and 200 were males. There is one governmental hospital one private hospital, three health center and four higher level private clinics rendering health services in the town. The town has 24 hours electricity and telecommunication services.

STUDY DESIGN

A cross sectional survey of quantitative study design was employed, to assess the level of knowledge of HIV/AIDS risk behavior among wolayta soddo preparatory school students. The dependent variable (HIV risk behavior knowledge) and independent variables (socio-demographic characteristics, History of sexual experience and Use of Substances and leisure time management) assessed at point in time.

SOURCE POPULATION

All students in Wolayta Soddo Preparatory School (grade 11 and 12) were source population.

STUDY POPULATION

The investigation included all randomly selected students from each grade that represented the source population. The study population was selected using simple random sampling technique. Wolayta Soddo Preparatory School has 26 sections of preparatory students (13 for grade 11 and 13 for grade 12). All 2340 students in each grade were considered as source population.

SAMPLE SIZE DETERMINATION

Sample size was determined by calculating using Epi Info version 3.5.1 single proportion sample size calculation program. The assumption was that the awareness about HIV risk behavior is 50% based on the previous study done in the year 2007 on HIV risk behavior knowledge in Gondar. A non-response rate of 10 %, and expected margin of error of 5 % within a 95 % of C.I. was considered. The calculated sample size is indicated in the table below.

Table-1: Sample size calculation

Total no of students	Precision	Confidence interval	power	Worst acceptable	Expected frequency	Sample size	Non response rate 10%	Total sample size
2340	**5%**	**95%**	**80%**	**45%**	**50%**	**330**	**33**	363

Sample size;- A total of 363study subjects were included in this study

SAMPLING TECHNIQUE

Simple random sampling technique was carried out. There is only one governmental preparatory school in the town and a total of 26 sections with average of 90 students in each section are available. By dividing a total sample size to a total of 26 sections and 14 students were allocated for each section. Study subjects were randomly selected from each section in each grade from their enrollment list. This list was used as a sample frame and was given random numbers and these numbers were randomly selected by using SPSS Version 15 software program.

DATA COLLECTION TOOLS AND PROCEDURES

Pre-tested and validated questionnaire was used to ask the selected participants. The questionnaire was adopted from previous similar studies and BSS questionnaires included demographic characteristics, sexual behaviors, substances abuse /leisure time management, and knowledge and communications on HIV/AIDS. Questions were originally developed in English and translated to Amharic and then back to English by another person who is fluent speaker of both languages to ensure validity. The first draft of the questionnaire was prepared and submitted to advisors for valuable comments before developing its final version. Two supervisors were trained about process of data collection for one day by the investigator. Their training ended by carrying out pre- testing (on those students from other school on similar setting on young people having similar socio demographic characteristics by considering 5 % of the total sample size and appropriate modifications were made after discussing with the supervisors such as skipping patterns and some other corrections to have the final version before starting the actual data collection process).Using the data collection instrument to assure the reliability and internal consistency of questionnaire. The data collected in the morning and afternoon session from each

study subjects. The investigator explained the objective of the study and accepted questions from the selected study subjects were answered. Individual discussions about the objective, immediate distribution of questionnaires to volunteers minimized non-respondents

Data Quality Assurance

The quality of the data was assured through careful design, translation, retranslation and pretesting of the questionnaire, proper training of supervisors of the and proper handling of the data. It was monitored frequently both in the field and during data entry that is all completed questionnaire was examined for its completeness and consistency, all incomplete data was identified and corrections were made on the spot. Every data was coded, entered into SPSS computer program and checked at the mid way and upon completion of whole data entry before statistical analysis performed.

Data Analysis

Data entry, clearing and cleaning was employed and analyzed by using SPSS, windows version 15, statistical program. Twenty one HIV /AIDS risk behavior knowledge related questions were scored in such a way that one point is given for the correct answer and zero for the incorrect one based on the respondent's response, which were summed up to dichotomized the overall knowledge in to two. Contingency tables were also used to see the association between the explanatory and outcome variables. Odds ratio with 95% confidence interval and logistic regression were employed to describe the strength of association between the selected study variables by controlling for the effect of possible confounders.

Measurement Variables

Dependent variable

- Knowledge for HIV risk behavior

Independent variable

Socio-Demographic variables;- Age, sex, marital status, religion, ethnicity, family income, source of financial support. History of sexual experience;- age at first sexual experience, sexual orientation, Mode and Pattern of sexual relationship, number of sexual partners, Use of Substances and leisure time management.

Operational definitions

Commercial sex workers: refer to females who exercise sexual intercourse in an exchange for money.

Condom use: The act of utilizing condom during any kind of sexual intercourse.

Knowledgeable: Respondents are considered as knowledgeable if he/she knows all of the following items; abstinence prevent HIV infection, a person can get HIV from multiple sexual partners, not using condom, sharing sharp materials, anal sex, performing sex with disabled, small child and virgin, non licensed tattoo and interrupted intercourse and washing genitalia after sex cannot prevent HIV infection.

Lifetime sexual partner: refers to the number of sexual partners a respondent could have till the survey.

Sexually active: Study subjects who claimed to have engaged in sexual act at least once prior to the study.

Risky sexual behavior: respondents who have had sexual intercourse with more than two sexual partners prior to the survey and inconsistent condom users.

Inadequate knowledge: Respondents are considered as having inadequate knowledge if he/she miss one or more of the following items; abstinence prevent HIV infection, a person can get HIV from multiple sexual partners, not using condom, sharing sharp materials, anal sex, performing sex with disabled, small child and virgin, non licensed tattoo and interrupted intercourse and washing genitalia after sex cannot prevent HIV infection.

ETHICAL CONSIDERATION

An ethical clearance was obtained from the University of Gondar. The investigator introduced herself by presenting official letter from University of Gondar and Addis Continental Institute of Public Health to Wolayta Soddo Preparatory School leadership, especially, to the school director for cooperation. Prior to collection of data, informed verbal consent was obtained from the respondents, similarly the respondents were informed the purpose of the study that it will contribute the necessary information for policy makers and other concerned bodies to look after the reproductive health needs of adolescents in the country and of the study area at large.

Confidentiality was guaranteed by not registering the names of the participants on the questionnaire format. A detailed explanation of the objective of the study (i.e. explaining that the aim of the study is to assess the knowledge of HIV risk behavior of the student) was given by the investigator.

RESULTS

Part one: Socio-demographic characteristics

The total number of students who responded to the questionnaire was 351 giving a response rate of 96.6%. Out of the total respondents, there were 141 (40.2%) female and 210 (59.8%) male students. Most of the students (86.3%) were in the range of 15-19 years of age while 13.4% were above 20 years. The mean age of the study subjects was 15.5 (±1.39 SD) years with the median age of 15 years. 105 (29.9%) were orthodox Christians while 225 (64.1%) were protestant by religion. Out of which 315 students (89.7%) were Wolayta by ethnicity. Majority of the students 308 (87.7%) were single, 8 (2.3%) were married and 35 (10%) of the respondents had boy/ girl friends. The number of participants who didn't know their family monthly income were 131 (37.3%) and 81 (23.1%) of the students came from family with less than 600.00 birr per month. Most of the students, 90.6%, were financially supported by their families. Table 2 indicates socio demographic characteristics of the study subjects.

Table 2: Distribution of Socio-demographic variables of Wolayta Soddo Preparatory School Students, Wolayta Soddo Jan, 2011 (n=350)

Socio demographic characteristics	NO(%)
Age	
15-19	303(87%)
20-26	47(13%)
Sex	
Male	210(59.8%)
Female	141(40.2%)
Religion	
Orthodox	105(29.9%)
Protestant	225(64.1%)
Muslim	6(1.7%)
Others	15(4.3%)
Marital status	
Single	308(87.7%)
Married	8(2.3%)
Boy/girl friend	35(10%)
Ethnicity	
Wolayta	315(89.7%)
Kembata	3(0.9%)
Gurage	3(0.9%)
Amahara	15(4.3%)
Tigire	2(0.6%)
Other	13(3.7%)
Family Monthly income	
<600	81(23.1%)
601-1200	57(16.2%)
1201-2000	35(10%)
>2001	39(11.1%)
I do not know	131(37.3%)
Others	5(1.4%)
Financial support	
parents	318(90.6%)
relatives	20(5.7%)
sponsorship	4(1.1%)
boy/girl friend	1(0.3%)
spouse	4(1.1%)

Part Two: Knowledge of risky behaviors for HIV/AIDS infection

A 21-item HIV Knowledge related questions were asked. Response options were yes, no, not sure and do not know. Correct answers were recorded as "1" and incorrect answers as "0", which were summed up to dichotomized the overall knowledge in to two. In the present survey to say an individual has adequate knowledge for HIV/AIDS risk behaviors he/she must know all of the following items; abstinence prevent HIV infection, a person can get HIV from multiple sexual partners, not using condom, sharing sharp materials, anal sex, performing sex with disabled, small child and virgin, non licensed tattoo and interrupted intercourse and washing genitalia after sex cannot prevent HIV infection. Accordingly, in response to the questions 188 (53.6%) respondents mentioned correct answer for all questions, regarding risky behavior for HIV transmission. Of which 123 (65.4%) were male and 65 (34.6%) were females. Table 3 indicates respondent's knowledge about HIV risk behaviors. It was found that 163 (46.4%) had inadequate knowledge. Three hundred twenty eight (93%) of respondents knew that having sex with more than one partner increase a person's chance of being infected with HIV, 306 (87.2%) of them knew People reduce their chance of getting the HIV by Abstaining from sexual intercourse, 289 (82.3%) of them responded that using a condom correctly prevent HIV, 240 (68.4%) responded a woman gets HIV if she has anal sex with a man. Three hundred forty one (97.2%) responded a person gets HIV from sharing a needle or sharp materials, 313 (89.2%) of respondents knew that getting a tattoo/piercing by a non-licensed person increases the risk of contracting HIV. Two hundred forty three (69.2%) knew Interrupted intercourse before orgasm does not protect against HIV, 289 (82.3%) responded as washing the genital after sex does not protect from HIV. Three hundred seven (87.5%) knew having sex with disabled or old woman does not protect from HIV, 299 (85.2%) of respondents mentioned having sex with small children does not protect

HIV/AIDS and 289(82.3%) mentioned having sex with a virgin does not protect from HIV/AIDS. However, 8% were of the opinion that people cannot reduce their chance of getting HIV by abstaining, and 6% respondents believed that having multiple sexual partners does not increase the chance of getting HIV.7.1% responded to the question Using a condom correctly prevent HIV ‘ with “no” answer. 10.3% believed that Interrupted intercourse before orgasm protect against HIV. 6.8% respondents responded with “yes” answer for question having sex with a virgin protect from HIV/AIDS? And 4.3% believed that washing the genital after sex protect from HIV and 13.4% respondents did not know about it. 7.7% believed that HIV cannot be transmitted by anal sex and 15.1% do not know about it. 8.3% believed that a woman cannot get HIV if she has sex during her menstrual period, 14.2% responded to " can a person get HIV through open or cut wound?" with "no” and 24.2% of the students responded to the question "can a person get HIV if she/he is taking antibiotics ?" with "no" and 12.3% were not sure, and 5.1% believed that a person can get HIV from mosquito and15.4% not sure about it, 5.7% of respondents believed that a person can get HIV by swimming with someone with HIV and 15.4% were not sure about it. Two hundred ninety (82.6%) of respondents have ever openly discussed about HIV with their peers while 61(17.4%) did not and 20.6% of them mentioned that the reason for not having open discussion about HIV is lack of knowledge while 22.2% were believed that discussion about HIV is not necessary. Two hundred (57.1%) of the respondents were participating in anti AIDS club in their school and the majority of them mentioned that they got an information on prevention of HIV and about HIV risk behavior.

Logistic regression analysis was carried out and sex and family income were found to have significant association with respondents HIV/ AIDS risk behavior knowledge. Males were found to be 1.65 times more knowledgeable about HIV/AIDS risk behavior than females (OR =1.653,

95% CI (1.075, 2.542). Those come from higher income family were less knowledgeable than their counterpart (OR=0.266, 95% CI (0.106, 0.671). age, ethnicity, religion, and other socio-demographic characteristics of the respondent had no significant relationship to levels of knowledge. Similarly, parental discussion, peer discussion, anti AIDS club participation had no significant relationship to levels of knowledge.(Table 4 results of multiple logistic regression analysis of HIV risk behavior knowledge by selected socio demographic characteristics of the respondents

Table 3: Distribution of HIV risk behavior knowledge among Wolayta Soddo Preparatory School students, Wolayta Soddo Jan, 2011

VARIABLES	Yes %	NO %	Not sure%	Do not know %
Having sex with more than one partner increase a person's chance of being infected with HIV	**93.4**	3.7	2.3	0.6
People reduce their chance of getting the HIV by Abstaining from sexual intercourse	**87.2**	8.0	4.6	0.3
Using a condom correctly prevent HIV	**82.3**	7.1	8.8	1.7
A woman get HIV if she has anal sex with a man	**68.4**	7.7	15.1	8.5
A person gets HIV from sharing a needle or sharp materials from someone with HIV?	**97.2**	1.7	0.9	0.3
Getting a tattoo/piercing by a non-licensed person increases the risk of contracting HIV	**89.2**	6.6	3.7	0.6
A person can get HIV if she/he is taking antibiotics	**57.3**	24.2	12.3	6.3
HIV can be transmitted from mother to child	**92.6**	4	3.1	0.3
A person can get HIV through open or cut wound	**74.6**	14.2	7.7	3.4
A woman can get HIV if she has sex during her menstrual period	**81.5**	8.3	7.1	3.1
Interrupted intercourse before orgasm protect against HIV	10.3	**69.2**	14	6.6
Washing the genital after sex protect from HIV	4.3	**82.3**	8.3	5.1
Having sex with disabled or old woman protect from HIV	3.7	**87.5**	4.3	4.6
Having sex with small children protect HIV/AIDS	5.4	**85.2**	5.7	3.7
Having sex with a virgin protect HIV/AIDS	6.8	**82.3**	6.8	4.0
A person can get HIV from mosquitoes	5.1	**76.9**	15.4	2.6
One can get HIV by sitting next to person with HIV	0.9	**94**	3.1	2
A person can get HIV from sharing meals with someone with HIV	0.9	**95.2**	3.4	0.6
A person can get HIV by sharing a glass of water with someone who has HIV	2.8	**90.6**	4.8	1.7
A person can get HIV by sharing toilet sits	0.6	**92.3**	5.7	1.4
A person can get HIV by swimming with someone with HIV	5.7	**77.8**	15.4	1.1

N.B. Percents totally exceed 100% because of multiple responses

Table 4: Results of multiple logistic regression analysis of HIV risk behavior knowledge by selected Socio demographic characteristics among Wolayta Soddo Preparatory School Students, Jan 2011

Characteristics	HIV risk behavior knowledge		Crude OR (95 % CI)	Adjusted OR (95 % CI)
	Yes	No		
Gender:				
Male	123	87	1.653(1.075,2.542)	**1.661(1.031,2.675)**
Female	65	76	1.00	1.00
Age :				
15-19	159	144	0.749(0.401,1.399)	0.836(0.503,1.445)
20-26	28	19	1.00	1.00
Religion:				
Orthodox	52	53	0.85(0.48,1.49)	.896(.518,1.549)
Christian Protestant	126	99	0.96(0.55,1.66)	.987(.574,1.69)
Others	10	11	1.00	1.00
Ethnicity:				
Wolayta	167	148	1.13(0.62,2.07)	.988(.542,1.801)
Others	21	15	1.00	1.00
Family monthly income				
<600	40	41	0.569(0.285,1.137)	0.543(0.263,1.122)
601-1200	36	21	0.822(0.371,1.819)	0.755(0.319,1.784)
1201-2001	19	16	1.168(0.672,2.029)	1.200(0.665,2.165)
>2000	30	9	0.293(0.123,0.694)	**0.266(0.106,0.671)**

Part three: Sexual behavior of the study subjects

The total number of one hundred five (29.9%) of the study subjects reported that they had experienced sexual intercourse. Out of this number 81 (77.1%) were males and 24 (22.9%) were females.The mean age of sexual onset was 16.7(±1.73) years. Of the sexually active study participants, 81 (77.2%) students had regular sexual partners and among male respondents who had engaged in sexual relationships 15 (14.3%) out of 81 have experienced it with commercial sex workers. They have initially decided to start sexual intercourse for different reasons. Love expression is the most important reason for sexual relation 69 (66.3%), while 11(10.6%) is due to peer pressure and 6(5.8%)were raped.12 (11.4%) of the respondents had reported that they have 2-3 life time partners and nine (8.6%) had more than 4. More than one life time partners was prevalent among the male students.77 (74.3%) of study subjects had vaginal intercourse while 10 (9.6%) were accounted for anal and oral intercourse and 17 (16.2%) of respondents experienced all type of mode of intercourse's. from those sexually active respondents only 18 (17.3%) used condom always strictly, 44 (42.3%) used most of the time, 36 (34.3%) had never used condom and 5.7% used condom occasionally. Table 5 indicates sexual behavior of the study subjects. 207 (59.0%) of adolescents have ever discussed about sexual matters with their parents while 144 (41.0%) did not. The major reasons mentioned for not having the discussion were primarily fear of parents 83 (58.9%), parents assume that discussion promotes promiscuity 56(39.7%), religious prohibition19 (13.5%), cultural prohibition 24(17%) and 22 (15.1%) assumed that discussion is not necessary.

Majority of the respondents 293(83.7%) out of 350 had never consumed alcoholic beverages, 336 (96.3%) had never smoked cigarettes, and 292(83%) had never chewed chat. Two hundred thirty one (66.6%) respondents watch movies, of those numbers 48 (21.2) watch pornographic

films and after watching 24 (10.6%) looking for sexual partners and perform sex. 29 (27.9%) had STI so far in their life time and 18 (60%) of them treated in public health facilities.35 (10%) of respondents have participated in night clubs and 13 (3.7%) were using shisha.

Table 5: Distribution of sexual behavior of sexually active students of wolayta soddo preparatory students, Jan 2011

Life time sexual behavior		Male	Female	Total (%)
Sexually active				
	Yes	85	20	105(29.9%)
	No	125	121	246(70.1%)
Age at first sex				
	13-16	50	5	55(52.4%)
	17-21	35	15	50(47.6%)
Life time sexual partner				
	CSW	15	0	15(14.3%)
	Regular	61	20	81(77.2%)
	Casual	3	0	3(2.9%)
	multiple sexual partners	6	0	6(5.7%)
Reason for sex				
	Love expression	60	9	69(65.7%)
	Seeking for better grade	0	2	2(1.9%)
	For prestige	0	2	2(1.9%)
	Peer pressure	11	0	11(10.5%)
	Financial gain	0	3	3(2.9%)
	Stress relief	7	2	9(8.6%)
	Rape	0	2	2(1.9%)
No. of sex partner				
	One	66	17	83(79%)
	Two	6	2	8(7.6%)
	Three	3	1	4(3.8%)
	>4	9	0	9(8.6%)
Type of sexual relation				
	Male to Female	81	16	97(92.7%)
	Female to Female	0	2	2(1.9%)
	both	0	2	2(1.9%)
	Male to female &Male to Male	4	0	4(3.8%)
Mode				
	Vaginal	58	20	78(74.3%)
	Oral	5	0	5(4.8%)
	Anal	5	0	5(4.8%)
	All	17	0	17(16.2%)
Condom use				
	user	10	9	19(18%)
	non user	74	12	86(72%)
Had STI				
	Yes	23	6	29(27.9%)
	No	57	18	75(72.1%)

DISCUSSION

The most challenging nature of HIV/AIDS is that its transmission is through sexual contact, a behavior that is relatively difficult for modification. Since HIV/AIDS prevention cannot be effective unless all sexually active persons consistently engage in safer sexual practices, it follows that efforts to intervene should take place as quickly as possible. For Effective prevention and handling of the epidemic, definitive and concrete knowledge on various ways of viral transmission and rejecting prevalent misconception is crucial. It appears that knowledge about AIDS may be important but not sufficient by itself to change behaviors. Although it is obvious that the prevention of HIV transmission is dependent upon the alteration of behavior, most would agree that appropriate knowledge and attitudes are prerequisites for such change.

In the context of HIV/AIDS, the ultimate aim of risk vulnerability reduction is to enable people exert control over their own risk by a process of individual and collective empowerment as well as to develop societal responses that create an environment in which safer and protective behavior can be practiced. Risk reduction strategies constitute the major approach being used in HIV/AIDS programs since their inception. Preventing HIV is thought to be achievable, because HIV is transmitted through the behavior of individuals and through a few recognized health care procedures. Of the various types of specific preventive measures available, the most cost-effective and probably efficient means of controlling the spread of AIDS in Africa and elsewhere is health education of the general population and those engaging in high-risk behaviors.

In Ethiopia the available reports showed that provision of information on HIV risk behavior to adolescents is not satisfactory both in terms of size of population and reaching different areas of

the country. This study has tried to address part of this gap by assessing the level of knowledge of HIV risk behavior and sexual behavior among Wolayta Soddo Preparatory School students, SNNPR by utilizing a cross sectional survey of quantitative study design.

Even though the study found that knowledge of HIV risk behavior was encouraging, but generally was not satisfactory enough to sustain adequate HIV/AIDS response in a context of high and widespread HIV/AIDS prevalence,. 328 (93%) of respondents knew multiple sex increases a person's chance of being infected with HIV, 306 (87.2%) of them knew Abstaining reduce chance of HIV infection, 289(82.3%) Using a condom correctly prevent HIV, 240 (68.4%) knew anal sex can transmit HIV, 341(97.2%) A person gets HIV from sharing sharp materials, 313(89.2%) Getting a tattoo/piercing by a non-licensed person increases the risk of contracting HIV, 243(69.2%) knew Interrupted intercourse does not protect against HIV, 289(82.3%) Washing the genital after sex does not protect from HIV, 307(87.5%) Having sex with disabled or old woman does not protect from HIV, 299(85.2%) Having sex with small children does not protect HIV/AIDS and 289(82.3%) Having sex with a virgin does not protect from HIV/AIDS. Those respondents who have responded correct answer for all questions mentioned above are considered as knowledgeable. The study result indicated that 188 (53.6%) respondents had a correct knowledge on HIV risk behavior. it is similar with a study result of senior high school students in Jimma(32) and Harar (33). In this study being male found to influence adolescents' knowledge of HIV /AIDS risk behavior positively and coming from high level income family were found to influence adolescents' knowledge of HIV /AIDS risk behavior negatively . In one study with a similar age group among Kenyan high school students, 2.9% had misconceptions of transmission of HIV through mosquitoes as compared to 5.1% in

this study (34). This study showed that10.3% of respondents believed that interrupted intercourse protects a person from HIV, 14% not sure about it and 6.6 do not know. 8.3% gave “not sure” response for does washing genital area after sex protect from HIV? , 5.1% do not know about it. 24.2% believed that taking anti-biotics protect a person from getting HIV, 5.4% of respondents agreed that sex with small child protect from HIV, 5.7% not sure about it, and 3.7% do not know about it. For statement “can having sex with virgin protect from HIV infection”? 6.8% responded “yes”, 6.8% not sure, 4% do not know. 5.7% agreed and that 15.4% responded “not sure” to the statement swimming with someone with HIV can transmitte the virus. These findings are slightly higher than that of similar studies done in South Africa. Some of incorrect responses may be explained by lack of information about HIV risk behavior. Incorrect responses may be based on cultural and other beliefs that may need special educational efforts to change.

29.9% of the participating students admitted to having sexual experience, accounting for 77.1% of the boys and 22.9% the girls. These figures are relatively low when compared with the results of similar studies that ranged from 31-59% in Northern Ethiopia (35,36) in Southern Ethiopia (37); and 32-41 % in Addis Ababa (38,39). This could be attributed either to shyness of the respondents to respond questions related to sensitive issues or cultural and /or religious influence. In USA and Canada the figures were between 46-72% for boys and 24%-72% for girls (40); In Europe it was between 18.9%-78% for boys, and 17%-45% for girls (40). The mean age at first sexual intercourse in this study was 16.7 years for males and 16 for females. More than 60 % of the participants reported to experienced sexual intercourse before the age of seventeen. studies among high school students from the different parts of the country indicated mean age at first sexual intercourse to range from 15.3 to 16.5 years (41,42). A general survey done at Addis Ababa, Bahir Dar, Awassa and Dire Dawa revealed that the age at first sexual intercourse to be

17-18 years (43). Surveys from a number of African countries also documented that there are early sexual initiation.66.3%of the sexually active respondents claimed that the main reason given for first sexual encounter was fell in love, this is much higher than the results of previous studies (43.45, 46,47,48,)

10.6% is due to peer pressure and 5.8% are raped, indicating either unplanned encounter or circumstances creating unfavorable situations for making responsible decisions. 14.3% of the sexually active students admitted to having had sex with female commercial sex workers, This finding is interestingly lower than the result of previous studies and could be explained by the income status of the respondents as majority of students 90.6% were financially supported by their families and 20.0% of the sexually active students reported also that they had had two or more sexual partners. The result obtained for this study was higher than that of south Gondar (18.2%), but lower than Addis Ababa (25.1 %) and that of Bale (47.7 %) and east Gojjam (46.1 %) (49, 50, 51, 52). In this study only 17.3% students used condom always strictly, this figure seems lower to earlier report (53), this indicates that the utilization of condoms is still not satisfactory. Moreover, 27.9% of sexually active adolescents had the history of sexually transmitted diseases It requires intense effort to convince these groups of adolescents to adopt the use of condoms. The study subjects who have ever had one life time sexual partner found to use condom less likely compared to their counter parts.

41.0% did not discuss about sexual matters with their parents mainly due to fear of their parents' and 58.9% parents assume that discussion promotes promiscuity followed by cultural and religious prohibition. This finding was comparable with the figure obtained for young people in rural town of Ethiopia, Zway, which indicated that more than half of the students believed that

it is unacceptable to discuss growth changes and sexual matters with parents and their preference being their peers as parents had little knowledge regarding adolescents' sexual behavior (54).

Majorities of the respondents have never drink alcoholic beverages, smoked cigarettes, chewed khat and abused substances. This may be explained by the religion influence as majority of the study subjects (64.1%) are Protestants or due to other socio cultural factors.

STRENGTH and LIMITATION OF THE STUDY

Strength of the study

This study has tried to assess the level of knowledge of HIV risk behavior together with sexual behavior among preparatory school students and identified the level of their knowledge on risky behavior that expose a person for HIV infection and determined the magnitude of risky sexual behaviors.

The questionnaire was adopted from standard previous studies like Family Health International Behavioral Surveillance Survey (BSS) questionnaire for HIV /AIDS and other relevant studies and pre tested on similar settings and necessary modifications were made to minimize the difficulty during data collection.

Limitations of the study

Possibility of underreporting of risky sexual behavior due to personal matters of sensitive issues

Qualitative way of data collection was also not used and this might have not enabled the study to exhaust all possible responses.

CONCLUSION

Even though the study found that knowledge of HIV risk behavior was encouraging, but generally was not satisfactory enough to sustain adequate HIV/AIDS response in a context of high and widespread HIV/AIDS prevalence, there is still room for improvement. These gaps mostly concern the modes by which HIV infection can or cannot be transmitted.

It is essential to reach young people before they engage in high risk behaviors. Information on HIV/AIDS and reproductive health, as well as life skills, should be integrated in to primary school curricula and offered through the school years.

Some socio-demographic factors are still influencing the awareness of HIV/AIDS and sexual behavior of adolescents in the study area.

Among the sexually active students more than 60% in this study were sexually engaged by age sixteen and also practiced high risk sexual behavior that is unprotected sex, multi- sexual partner, and sex with female commercial sex workers.

There is inadequate family and social support to discuss about sexuality and protective measures.

From these one can also conclude that the major problems that influence sexual behavior of the study subjects are still linked to lack of accurate information on adolescent reproductive health, social and cultural factors, peer influence, and lack of support from families.

RECOMMENDATIONS

Consistent Provision of accurate information about adolescent reproductive health in general and HIV/AIDS risk behavior in particular should be provided to the school adolescents by the concerned agencies to minimize misconceptions.

Upgrading the capacity of school clubs, peers, and teachers would help to disseminate accurate information.

As youth clubs are increasingly being recognized as an important avenue for disseminating reproductive health information to the young, adolescent reproductive health club should be established in the school-by-school adolescents.

Create opportunity to Work with adolescents, promote their participation and equipped with life skills to put knowledge in to practice.

The local Community should be taught of the importance of discussing sex and related issues with their children so as to increase their awareness.

Information, Education and Communication on HIV/ AIDS risk behavior in an effort to enhance their level of awareness by involving parents, religious and other community leaders and relevant organizational sectors as well.

REFERENCES

1. Joint United Nation Program on HIV-1/AIDS.UNAIDS/WHO. AIDS epidemic update. Geneva, World Health Organization 2005, 1(3):10-24.
2. *The Report on the Global AIDS Epidemic, UNAIDS, August, 2008*.
3. CSA, O. M. Ethiopia Demographic and Health Survey. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro. 2005,3(2):5-8.
4. FHAPCO.Report on Progress towards Implementation of the UN Declaration of Commitment on HIV/AIDS. Addis Ababa: Federal HIV/AIDS Prevention and Control Office. (2008).
5. UNAIDS. (2007). Geneva: UNAIDS and WHO.
6. UNAIDS. (2008). Geneva: UNAIDS and WHO.
7. Yemane B et al, Y. M. HIV / AIDS IN ETHIOPIA AN EPIDEMOLOGICAL SYNTHESIS. Washington, DC: World Bank Global HIV/AIDS Program(2008)..
8. Ministry of Health. AIDS in Ethiopia. Addis Ababa, Ethiopia, Disease Prevention and Control Department, Ministry of Health, 2006, 5th ed.
9. Government of Ethiopia. Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia. Addis Ababa, Ethiopia. August, 2008.
10. FHAPCO. (2006). Addis Abeba: MOH and FHAPCO.
11. MOH. (2006). Adiss Abeba: Minstry of Health.
12. MOH. (2006). Addis Abeba: MOH and FHAPCO

13. Hesketh T, Duo L, Li H, Tomkins AM: Attitudes to HIV and HIV testing in high prevalence areas of China: informing the introduction of voluntary counseling and testing programmes. 2007, 4th ed
14. Chinese Ministry of Health and UNAIDS, AIDS Epidemic prevention progress in China. *Beijing, People's Health Press:* **2006**, pp 16-21.

15. M. Danjin & A. T. Onajole : HIV/AIDS Risk Behavioural Tendencies Among Secondary School Students In Gombe (Nigeria). *The Internet Journal of Health.* 2010 Volume 11(1)
16. Siegel D, Lazarus N, Krasnovsky F, Durbin M, Chesne M: AIDS knowledge, attitudes and behaviour among inner city, china, junior high school students, 2006,2nd ed
17. Morris K: Transfusion-related HIV outbreak in Kazakhstan children**.** *The Journal of School Health* 2007, **61**(4)**:**160-165.
18. Diaz T, C. S. Socioeconomic differences among people with AIDS: results from a multistate surveillance project. American Journal of Preventive Medicine , 2005;10:217–222. .
19. UNFPA: Preventing HIV infection. Global Youth Partners. Advocating for increased access by young people to information, education and services in the area of HIV prevention: http://www.unfpa.org/hiv/ gyp/index.htm.2007
20. Jichuan, C.: Investigation on knowledge, practice about STDs and AIDS among Ningde Normal School students. *Chinese J. Health Education*, **2006**, *19(11)*, 853-854.
21. Hongbin, Z.: Investigation of HIV Knowledge among High Risk Groups in Maanshan City. *J. Anhui J Preventive Medicine,* **2005**, *11(1),* 17-18.

22. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance-United States, 2007.
23. Dittus P, M. K. Why Parents Matter!: the conceptual basis for a community-based HIV prevention program for the parents of African American youth. Journal of Child and Family Studies , 2004;13(1):5–20.
24. Centers for Disease Control and Prevention. Young people at risk: HIV/AIDS among America's Youth, March 2009. Available at: http://www.cdc.gov/hiv/
25. Kebede D, Aklilu M, Sanders E. The HIV epidemic and the state of its surveillance in Ethiopia. Med J, 2008;38(4):283-302Ethiop
26. Geiger S. Sexual behavior & knowledge of HIV/AIDS & other STDs. A survey of senior high school students Ethiop J Health Dev, 2005;4(2):123-131.
27. Korra A, Haile M. Sexual behaviors & level of awareness on reproductive health among youths evidence from Harar, Eastern Ethiopia. Ethiop J Health dev, 2008;13(2):107-113.
28. Ibrahim N. Factors that influence adolescent's exposure to HIV/AIDS in Bale zone of Oromiya regional traditional state .A thesis for masters of public health, May 2004, Addis Ababa university (unpublished).
29. Save the children /USA/Ethiopia Field office Baseline Survey report on ARH in government high schools of Addis Ababa. Oct 2007, Addis Ababa, Ethiopia.
30. Fitaw Y and Worku A. High risk sexual behavior and pattern of condom utilization of the Gondar high school students, North Western Ethiopia. Ethiop J Health Dev., 2009;16(3):335338.
31. Geber S. Sexual behavior and knowledge of AIDS and other STDs; a survey of senior high school students. Ethiop. J. Health Dev .2009 4(2); 123-131.

32. Population Reports, “Age at marriage” 2006; vol. XX (4): 25-29.

33. Korra A., Haile M.Sexual behavior and level of awareness on reproductive health among youths: Evidence from Harar, western Ethiopia. Ethiop. J. Health Dev .2008; 13(2): 107 114.

34. Pattullo, A.L.S., M. Malonza, G.G. Kimani, A. Muthee, P.A.O. Otieno, K. Odhiambo, S. Moses and F.A. Plummer, Survey of knowledge, behaviour and attitudes relating to HIV infection and AIDS among Kenyan secondary school students. Kenya AIDS Care, 2006, 2 (6): 173-181.

35. Ismail S. etal. High risk sexual behaviors for STI/HIV, pregnancies, and contraceptive use among high school adolescents in a rural town, North West Ethiopia. Ethiop. J. Health dev. 2006; 11 (91); 29-36

36. Fantahun M, Chala F, Loha M, Knowledge, attitude and practice of family planning among high school students in North Gondar Ethiopia. Ethiop. J. Health Dev. 2007; 33 (10); 21-29

37. Taffa N. Sexual activity of out of school youth, and their knowledge and attitude about STD and HIV/AIDS in Southern Ethiopia. Ethiop. J. Health Dev. 2008; 12 (10); 17-23

38. Pela OA, and Platt JJ. AIDS in Africa: emerging trends. Soc. Sci. Med. 2009; 28: 1-8

39. Abate S. Determinants of high risk sexual behaviors for HIV/AIDS among out of school youth in Addis Ababa Ethiopia. [Dissertation] Department of Community Health, Addis Ababa University 2009.

40. Boyer C.B and S.M Keagles, “AIDS risk and prevention among adolescents, South Africa; AIDS prevention center, 2009, 5th ed.

41. Ibrahim N. Factors that influence adolescent's exposure to HIV/AIDS in Bale zone of Oromiya regional traditional state .A thesis for masters of public health, May 2004, Addis Ababa university (unpublished).
42. Population Reports, "Age at marriage" 2007; vol. XX (4): 25-29.
43. Boyer C.B and S.M Keagles, "AIDS risk and prevention among adolescents, "Sco.Sci. Med. 2006; 33 (1): 11-23
44. Tyden T., L. Nordan and L. Ruusuvaara, "Swedish adolescents Knowledge of STDS and their attitude to the condom," MIDWIFERY. 2009; 7: 25-30.
45. Joint United Nations Program on HIV/AIDS. Report on HIV/AIDS Global epidemic. Geneva, Switzerland. UNAIDS, June 2008, 2nd ed
46. Cernada G.P., et.al. "Implications for adolescents sex education in Taiwan," Studies in Family planning. 2006; 17 (4): 181-187
47. DSE. Sexual Education and Reproductive Health: Sexual Education and Reproductive Health of Young people in African Countries South of Sahara, 2008; Oktoberdruk GMBH, Berlin
48. Eshetu F. The attitude of students, parents and teachers towards the promotion and Provision of condoms for adolescents in Addis Ababa, .Ethiop.J. Health Dev. 2005; 11(1):7-16.
49 Ibrahim N. Factors that influence adolescent's exposure to HIV/AIDS in Bale zone of Oromiya regional traditional state .A thesis for masters of public health, May 2004, Addis Ababa university (unpublished).
50. Fantahun M, Chala F, Loha M, Knowledge, attitude and practice of family planning among high school students in North Gondar Ethiopia. Ethiop. J. Health Dev. 2007; 33 (10); 21-29
51. Abate S; Determinations of risk sexual behaviour for HIV /AIDS among out of school Youth in Addis Ababa .An MPH thesis. Addis Ababa University, Dec.2009 (Unpublished).

52. Seifu A; reproductive health needs of Urban and rural out of school adolescents ineast Gojjam An MPH thesis Addis Ababa University, Dec 2005 (Unpublished).

53. Ismail S. etal. High risk sexual behaviors for STI/HIV, pregnancies, and contraceptive use among high school adolescents in a rural town, North West Ethiopia. Ethiop. J. Health dev. 2007; 11 91) 29-36

54. Abate S; Determinations of risk sexual behavior for HIV /AIDS among out of school Youth in Addis Ababa .An MPH thesis. Addis Ababa University, Dec.2007 (Unpublished).

Annexes

Annex: 1 Sample English questionnaire

Dear student:

This consent form is presented to you in order to ascertain about the health of young productive generation understanding of the existing magnitude of the problem and associated factor is important. This study is aimed to assess the HIV risk behavior knowledge of preparatory students and to generate information that can be used to design effective intervention strategies. You are selected to participate in this study. Selection has been done randomly using a lottery type of approach.

In order to attain the goal of this study we would like to ask your willingness and effective participation The study includes private and too personal sensitive life experiences questions to be filled by you. No need of writing your name, and ID number . It will be essential for the study if you may fill in all the information required to be filled in. There is no chance for anybody to identify who you are.

Please take few minutes to answer the questions.

Would you like to contribute in participating in this very important study?

Yes: I am willing to participate in this study. _____

Please go to the next page.

THANK YOU!

STUDENT SELF REPORTING QUESTIONNAIRE TO BE FILLED BY

PREPARATORY SCHOOL ADOLESCENTS OF WOLAYTA SODDO

The following are general information request for you to write appropriate responses in the space provide or encircle it/them.

Part-I: Socio-Demographic Characteristics

1.1 Age _____years

1.2 Sex 1.Male 2.Female

1.3 Religion

1. Orthodox 2. Protestant 3.Muslim 4. Others specify_____

1.4 Marital/partnership status

1. Single 2.Married 3.Has a steady boy /girl friend 4.Divorced

1.5 Ethnicity 1. Wolayta 2.Kembata 3.Gurage 4. Others specify___

1.6 Your family income per month in BIRR

1. <600.00 2. 601-1200.00 3.1201-2000.00 4. >2001.00

5. I don't know 6. Other specify _____

1.7 Sources of your financial support

1.Parent 2. Relative 3. Sponsorship 4.Boy/girl friend

5. Other source, specify_____

Part II. Knowledge and communication about HIV/AID risk behavior

2.1 Can a person get HIV from mosquitoes?

1. Yes 2. No 3. I am not sure 4.I do not know

2.2 One can get HIV by sitting next to a person with HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.3 Can a person get HIV from sharing a meal with someone with HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.4 Can a person get HIV by sharing a glass of water with someone who has HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.5 Can a person get HIV by sharing toilet sits with a person who has HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.6 Can a person get HIV by sitting in a hot tub or a swimming pool with a person who has HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.7 Does pulling out interrupted intercourse before orgasm protect against HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.8 Does washing the genital area after sex protect from HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.9 Can having sex with a disabled or old woman cure HIV/AIDS?

1. Yes 2. No 3. I am not sure 4.I do not know

2.10 Can having sex with small children cure HIV/AIDS?

1. Yes 2. No 3. I am not sure 4.I do not know

2.11 Can having sex with a virgin prevent HIV/AIDS?

1. Yes 2. No 3. I am not sure 4.I do not know

2.12 Can people get the HIV because of the curse of God or other supernatural means?

1. Yes 2. No 3. I am not sure 4.I do not know

2.13 Can a person get HIV if she or he is taking antibiotics?

1. Yes 2. No 3. I am not sure 4.I do not know

2.14 Can people reduce their chance of getting the HIV by abstaining from sexual intercourse?

1. Yes 2. No 3. I am not sure 4.I do not know

2.15 Can having sex with more than one partner increase a person's chance of being infected with HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.16 Can using a condom correctly prevent HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.17 Can Pulling out the penis before a man climaxes/ (ejaculates) keep a woman from getting HIV during sex?

1. Yes 2. No 3. I am not sure 4.I do not know

2.18 Can a woman get HIV if she has anal sex with a man?

1. Yes 2. No 3. I am not sure 4.I do not know

2.19 Can oral sex (mouth –to- penis or mouth- to- vagina) prevent a person from getting HIV infection?

1. Yes 2. No 3. I am not sure 4.I do not know

2.20 Can a woman get HIV if she has sex during her menstrual period?

1. Yes 2. No 3. I am not sure 4.I do not know

2.21 Can you get HIV through an open or cut wound?

1. Yes 2. No 3. I am not sure 4.I do not know

2.22 Can a person get HIV from sharing a needle or sharp materials from someone with HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.23 Getting a tattoo/piercing by a non-licensed person increases the risk of contracting HIV?

1. Yes 2. No 3. I am not sure 4.I do not know

2.24 Can HIV/AIDS be transmitted from mother to child?

1. Yes 2. No 3. I am not sure 4.I do not know

2.25 Do you think that you are /your partner is at risk of getting HIV? (Note: if you do not have any sexual partners please skip this question to question 2.27)

1. Yes 2.No 3.I do not know

2.26. If 'YES 'in which of the following ways you/ your partner can be prevented from being infected with HIV infection. (Encircle all possible answer)

1. Abstaining from sexual relationship
2. Be faithful to one to one sexual partner
3. Regular condom use during any sexual relationships
4. Avoiding sexual relation with sex worker
5. Limiting number of sexual partners
6. Avoiding blood transfusion not been tested for HIV
7. Avoiding unsafe injection
8. Having boy/girl friend
9. Use of holy water
10. Eating good foods

If your answer to question 2.25 is “No I do not think that we are at risk of getting HIV” continue on 2.27

2.27. Have you ever discussed –openly with your parents about sexual matters

1. Yes 2.No

2.28 If your answer is “YES” in which of sexual matters have you had open-discussion with your parents? (Encircle all possible answer)

1. How to prevent HIV infection
2. When to have first sexual relationship
3. About the risk of premarital sex
4. About condom use
5. Risk of making sex with sex worker/high risk group/
6. Benefit of abstaining before marriage
7. Risk of multiple sexual partners
8. How to select sexual partner
9. About risk of unprotected sex
10. . The risk of using alcohol, chat, cigarette smoking and watching phonographic films
11. Other, specify_____

2.29 If your answer is “NO” to 2.27 what are the reasons for not having open-discussion about sexual matters with your parents?

1. There is fear to openly discuss about the matter at parent child level of relationship.
2. They assumes that discussion promotes promiscuity
3. Forbidden in your religion

4. Undermining as you are young enough for this matter

5. Cultural influence

6. Other ,specify_____

2.30 Do you respect the idea or opinion of your parents that you get from open-discussion about sexual matters?

1. Yes 2.No

2.31 If your answer to 4.31 is “YES” did it bring change in your sexual relationship behavior?

1. Yes 2. No

2.32 Have you ever openly discussed about HIV with your partner/ peer?

1. Yes 2.No

2.33 If your answer is ‘’NO’’ what are the reasons for not having open-discussion about HIV?

1. There is fear to openly discuss about HIV

2. We do not have knowledge about HIV/AIDS

3. It is not necessary

4. Other, specify_____

2.34 Do you have a friend with multiple sexual partners in the past years?

1. Yes 2. No

2.35 Do you have friends who discourage condom use during sexual intercourse?

1. Yes 2.No

2.36 Do you have friends who encourage night club participation?

1. Yes 2.No

2.37 Do you have friends who encourage having boy/girl friends?

1. Yes 2.No

2.38 Do you participate in anti-AIDS club in your school?

1. Yes 2. No 3.No anti-AIDS club

2.39 IF Yes what type of information did you get?

1. How to prevent HIV infection

2. The ways of HIV transmission

3. HIV infection risk behaviors

4. All of the above

5. none of the above

Part III. History of Sexual Experience /Sexual Risk Behavior

(Your response to the following questions will be kept confidential; the investigator also can't know who you are. No one can know you. Be honest and provide true information. Your sincere responses are respected.)

3.1 Have you ever had sexual relationship(s) so far in your life?

1. Yes 2.No

If your answer is'' NO" go to part –__**IV.**__

3.2 If your answer is "YES" when did you experienced your very first sexual relationship?

Age_____

Grade _____ 1. Junior secondary school (7-8)

2. High school (9-10)

3. Preparatory (11-12)

3.3 Who has so far been your sexual partner? (Encircle all your possible partners)

1. Regular partner
2. Commercial Sex worker
3. Casual partner
4. Person who had multiple sexual partners
5. old men/women
6. Other specify_____

3.4 Reason for sexual relationship

1. Love expression

2. Seeking for better grade

3. Drive for gain of prestige

4. Peer pressure

5. Financial gain

6. Get relief from stress

7. Raped

8. Others, specify_____

3.5 How many sexual partners did you have in the past as well as at present?

1.One 2. Two 3. Three 4. > Four

3.6 Type of sexual relationship you make usually:

1. Male with female

2. Female with same sex female

3. Men with the same sex men

4. 1and 2 5.1 and 3

3.7 Mode of sexual relationship you ever experienced:

1.oral 2. Anal 3.Vaginal 4. All

3.8 How frequent do you use condom during sexual relationship?

1. Always strictly 2.most of the time 3.occasionally 4. Never

3.9 Did you ever experience any genital ulceration or discharge in your life time? In other words did you have any sexually transmitted infection symptoms in your life time?

1. Yes 2.No

3.10 If 'YES' where did you get your treatment

1. Public health facilities 4. Self –treated

2 .Private clinic 5.Traditional healer

3. Private pharmacy 6. Holy water

Part IV. Use of Substances and leisure Time Management:

4.1 Do you have a habit of drinking alcohol?

1 .Yes 2.No

If your answer is “NO’’ go to question 4.5

4.2 If “’YES’’ How often do you drink alcohol?

1. Always 2.Often 3. Occasionally 4.rarely

4.3 Did you have any experience of sexual relationship with a causal partner(s) immediately after drinking alcohol?

1. Yes 2.No

4.4 If “YES”, how often did you use condom?

1. Always strictly 2. Often 3. Occasionally 4.rarely

4.5 Do you have a habit of chewing chat?

1. Yes 2.No

If your answer is ‘’NO’’ go to question 4.9

4.6. If “YES” how often do you chew chat?

1. Always 2.Often 3. Occasionally 4.rarely

4.7 Did you have any experience of sexual relationship with a causal partner(s) immediately after chewing chat?

1. Yes 2.No

4.8 If “YES”, how often did you use condom?

1. Always strictly 2. Often 3. Occasionally 4.rarely

4.9 Do you smoke cigarettes?

1. Yes 2. No

4.10 Do you watch movies?

1. Yes 2. No

4.11 If "YES" to question3.10 what types of movies do you watch?

1. Love story & pornographic 2. Comedy & pornographic 3.pronographic

4. Adventure 5. War 6.Other, specific_____

4.12 Did you ever participate in night clubs?

1. Yes 2.No

4.13 What do you do after watching movies?

1. Drink alcohol 2. Look for a sexual partner 3. Perform sex

4. Just for entertainment

4.14 Do you have any experience of use of the following substances/ addictive drugs?

1. Shisha 2.hashish 3.marijuana 4. None of them 5. All of them

6. Others specify_____

Thank you very much for your commitment to participate in this study.

Annex 2: Sample Amharic Questionnaire

ተማሪው በግል ጽፎ መልስ የሚሰጥበት መጠይቅ

ወላይታ

ውድ ተማሪ

ወጣቶች ጤናማ ሆነው እንዲገኙ ለማድረግ አሁን በእርሱ ላይ የሚታዩትን የጤና ችግሮችና ተዛማጅ ባህሪያት አስቀድሞ መገንዘብ በጣም ጠቃሚ ነው፡፡

ይህን አስመልክቶ የፕሪፓራቶሪ ተማሪዎች ለ ኤች አይቪ ሊያጋልጡ ስለሚችሉ ባህሪያት ያላቸውን ግንዛቤና አውቀት ለመረዳት ይህ ጥናት ተዘጋጅቷል፡፡ አንቺ /አንተ ለዚህ ጥናት ተመርጠሻል/ህል፡፡ የምርጫውም ሁኔታ ነሲባዊ የምርጫ ዘዴን በመጠቀም ነው፡፡

ጥናቱ በካርታ በግል ህይወት ዙሪያ ጥያቄዎች አሉት፡፡ ስለዚህ ጥናቱ በትክክል የታሰበለትን ግብ እንዲመታ የአንተን/አንቺን ከፍተኛ ትብብር ይፈልጋል፡፡

በተዘጋጀው መጠይቅ ላይ ስም መፃፍ አያስፈልግም፡፤ መልስህ/ሽ በሚስጥር የሚያዝ ነው፡፡ ማንም ሰው ማንነትሽን/ህን ለይቶ ሊያውቅ አይችልም፤፤ ጥቂት ደቂቃዎች ወስደህ/ሽ አስቢበት/ አስብበት

ታዲያ መጠይቆቹን ለመሙላት ፈቃደኛ ነህ/ሽ?

አዎ፡ ወደሚቀጥለው ገጽ ተሸጋገር/ሪ

አይደለም፡ አቁም፡፡

ከዚህ በታች ለተዘረዘሩት መጠይቆች ከተሰጡት ምርጫዎች ውስጥ በመምረጥ ወይም በተሰጠው ቦታ በመጻፍ ተገቢውን ምላሽ ስጥ/ስጪ፡፡

ክፍል አንድ፡- ማህበራዊና ዲሞግራፊያዊ ባህሪያት

1.1እድሜ…….

1.2 **ፆታ**

1.**ወንድ** 2. **ሴት**

1.3 **ሃይማኖት**

1. **ኦርቶዶክስ** 2. **ፕሮቴስታንት** 3. **መስሊም** 4. **ሌላ ካለ ይገለጽ**……

1.4 **የጋብቻ ሁኔታ**

1 **ያላገባ** 2. **ያገባ** 3. **በጓደኝነት** 4.**የታፋታ/ች**

1.5 **ብሄረሰብ**

1.**ወላይት** 2.**ከንባታ** 3.**ጉራጌ** 4. **ሌላ ካለ ጥቀስ**……..

1.6 **የቤተሰብ የወር ገቢ**

1.**ከ600 በታች** 2. **ከ601-1200** 3.**ከ1201-2000** 4.2001.00**በላይ**

5.**አላውቅም** 6.**ሌላ ካለ ጥቀስ**……

1.7 **የገንዘብ ድጋፉ የሚያደርግልህ/ሽ ማን ነው**;

1.**ቤተሰብ** 2.**ዘመድ** 3.**የእርዳታ ድርጅት** 4.**የፍቅር ጓደኛ**

5. **ሌላ ምንጭ ካለ ጥቀስ**…….

ክፍል ሁለት፡- ለኤች.አይ.ቪ በሽታ ተጋላጭ ሊያደርጉ ስለሚችሉ ባህሪያት እና

ስለ በሽታዉ ያለህን/ሽን ግንዛቤ/ እውቀትና ውይይት በተመለከተ

2.1 **የወላ ትንኝ አንድን ሰው ኤች.አይ.ቪ በሽታ ልታስይዝ ትችላለች;**

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.2 **ኤች.አይ.ቪ በደሙ ውስጥ ካለው ሰው ጋር አብሮ በመቀመጥ በሽታው ሊተላለፍ ይችላል**

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.3 **ኤች.አይ.ቪ በደሙ ውስጥ ካለው ሰው ጋር አብሮ በመመገብ በሽታው ወደ ጤነኛው ሰው ሊተላለፍ ይችላል**?

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.4 **ኤች.አይ.ቪ በደሙ ውስጥ ካለው ሰው ጋር የመመገቢያ እና የመጠጫ ዕቃዎችን አብሮ መጠቀም በሽታውን ሊያስተላልፍ ይችላል**;

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.5 **ኤች አይ.ቪ በደሙ ውስጥ ካለው ሰው ጋር የመጸዳጃ ቤቶችን በጋራ መጠቀም በሽታውን ሊያስተላልፍ ይችላል**;

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.6 **በመዋኛ ገንዳ ውስጥ ኤች.አይ.ቪ በደሙ ካለው ሰው ጋር አብሮ መዋኘት በሽታውን ሊያስተላልፍ ይችላል፡፡**

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.7 ወሲብ በሚፈጸምበት ጊዜ ወደ እርካታ ሳይደርሱ አቋርጦ መተው ከኤች.አይ.ቪ ሊከላከል ይችላል;

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.8 ወሲብ ከፈጸሙ በኋላ ብልትን መታጠብ ከኤች.አይ.ቪ ሊከላከል ይችላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.9 ከአልካ ጉዳተኞች ወይም በእድሜ በጣም ከገፉ ሰዎች ጋር ወሲብ መፈጸም ከኤች.አይ.ቪ በሽታ ሊከላከል ይችላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.10 ከህጻናት ጋር የግብረ ስጋ ግንኙነት መፈጸም ከኤች.አይ.ቪ በሽታ ሊከላከል ይችላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.11 ከድንግል ልጃገረዶች ጋር ወሲብ መፈጸም ከኤች.አይ.ቪ በሽታ ሊከላከል ይችላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.12 ከተፈጥሮ በላይ በሆነ ኃይል ወይም በእግዚአብሄር ቁጣ ምክንያት ሰዎች የኤድስ በሽታ ሊይዛቸው ይችላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.13 አንድ ሰው የጸረ ህዋሳት መድሃኒት እየወሰደ እያለ ኤች.አይ.ቪ ሊይዘው ይችላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.14 ወሲብ ከመፈጸም መታቀብ አንድ ሰው ለኤች.አይ.ቪ በሽታ ያለውን ተጋላጭነት ሊቀንስ ይቻላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.15 ከተለያዩ ሰዎች ጋር ወሲብ መፈጸም ለኤች.አይ.ቪ በሽታ ያለውን ተጋላጭነት ሊጨምር ይችላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.16 ኮንዶምን በትክክል መጠቀም ኤች.አይ.ቪን ሊከላከል ይችላል ?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.17 በወሲብ ወቅት የወንድ ዘር ፍሬ በሴቷ ብልት ውስጥ ከመፍሰሱ በፊት ግንኙነቱ ቢቋረጥ ሴቷ ለኤች.አይ.ቪ በሽታ ተጋላጭ አትሆንም

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.18 አንዲት ሴት በፊንጢጣዋ በኩል ከአንድ ወንድ ጋር ወሲብ ብትፈጽም ኤች.አይ.ቪ ሊይዛት ይችላል?

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.19 በአፍ የሚደረግ ወሲብ (የወንድ ወይም የሴት ብልትን ከአፍ በማስገባት) አንድ ሰው ኤች.አይ.ቪ በሽታ እንዳይዘው ይከላከላል;

1.አዎ 2. የለም 3. እርግጠኛ አይደለሁም 4. አላውቅም

2.20 **አንዲት ሴት በወር አበባ ወቅት ወሲብ ብትፈፅም ኤች.አይ.ቪ ሊይዛት ይችላል**?

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.21 **በሰውነት ቆዳ ላይ በተከሰቱ ክፍተቶች/ቁስሎች አማካኝነት ኤች.አይ.ቪ የሚያስይዝ ህዋሳት ወደ ሰውነት ውሰጥ ሊገባ ይችላል**?

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.22 **ኤች.ኤ.ቪ በደም ውስጥ ካለው ሰው ጋር እንደ መርፌና ምላጭ የመሳሰሉ ስለታም ነገሮችን በጋራ መጠቀም ጤነኛውን ሰው ለበሽታ ሊያጋልጠው ይችላል**?

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.23 **ንጽህናቸው አስተማማኝ ባልሆኑ መሳሪያዎች ንቅሳት መነቀስ ለኤች.አይ.ቪ በሽታ ሊያጋልጥ ይችላል**?

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.24 **ኤች. አይ.ቪ ከእናት ወደ ልጅ ሊተላለፍ ይችላል**?

1.**አዎ** 2. **የለም** 3. **እርግጠኛ አይደለሁም** 4. **አላውቅም**

2.25 **አሁን ያለህ/ሽ ፆታዊ ግኑኝነት ለኤች.አይ.ቪ ያጋልጠኛል ብለህ/ሽ ታስቢያለሽ/ህ**? (**ምንም ዓይነት ፆታዊ ግንኙነት ከሌለህ/ሽ ወደ ጥያቄ** 2.27 **እለፍ/ፊ**

1.**አዎ** 2. **የለም**

2.26 መልስህ/ሽ አዎ ከሆነ ከሚከተሉት በየትኛው መንገድ ነው እራስህን/ሽን ወይም የወሲብ ጓደኛሽን/ህን ለኤች.አይቪ በሽታ ተጋላጭ እንዳይሆን /ትሆን ልታደርግ/ጊ የምትችለው/ይዉ?

(መልስ ሊሆኑ የሚችሉት በሙሉ ይከበቡ)

1. ወሲብ ከመፈጸም መታቀብ

2. አንድ ለአንድ መወሰን

3. ሁልጊዜ በወሲብ ወቅት ኮንዶም መጠቀም

4. ከሴተኛ አዳሪ ሴቶች ጋር ወሲብ አለመፈጸም

5. ከተለያዩ ሰዎች ጋር ወሲብ ከመፈጸም መቆጠብ

6. ኤች.አይ.ቪ ምርመራ ያልተደረገለትን ደም ከመቀበል መቆጠብ

7. ንጽህናው አስተማማኝ ባልሆነ መርፌ አለመጠቀም

8. የፍቅር ጓደኛ መያዝ

9. የፀበል ውሃ መጠቀም

10. ጥሩ ጥሩ ምግብ መመገብ

ለጥያቄ ቁጥር 2.25 መልስህ/ሽ የለም ከሆነ ወደ ጥያቄ 2.27 እለፍ/ፊ

2.27 ከቤተሰቦችህ/ሽ ጋር ስለጾታዊ ግንኙነት በግልጽ ተወያይተህ/ሽ ታውቂያለህ/ሽ?

1.አዎ 2. የለም

2.28 መልስህ አዎ ከሆነ ከሚከተሉት በየትኞቹ ጾታዊ ግንኙነት ርዕሶች ላይ ነው ግልጽ ውይይት ከቤተሰቦችህ ጋር አድርገህ የምታውቀው?(መልስ ሊሆኑ የሚችሉ በሙሉ ይከበቡ)

1.ኤች.አይ.ቪን እንዴት መከላከል እንደሚቻል

2.ጾታዊ ግንኙነት መቼ መጀመር እንዳለበት

3.ከጋብቻ በፊት የሚደረግ ወሲብ ሊያስከትል የሚችለውን ችግር

4.ስለ ኮንዶም አጠቃቀም

5.ከሴተኛ አዳሪ ሴቶች ጋር ወሲብ መፈጸም ሊያስከትል የሚችለውን ችግር

6.ከጋብቻ በፊት ወሲብ ከመፈጸም መታቀብ

7.ለፆታዊ ግንኙነት ጓደኛ እንዴት መምረጥ እንዳለብህ/ሽ

8.ከተለያዩ ሰዎች ጋር ወስብ መፈጸም ሊያስከትል የሚችለውን ችግር

9.ራስን አደጋ ላይ ሊጥል ስለሚችል ጾታዊ ግንኙነት

10.አልኮል፣ ጫት፣ ሲጋራ መጠቀም እንዲሁም ደግሞ የወሲብ ፊልሞችን አዘውትሮ መመልከት ስለሚያስከትለዉ አደጋ

11. ሊላ ካለ ይገለጽ…….

2.29 **ለጥያቄ ቁ**2.27 **መልስህ/ሽ የለም ከሆነ በጾታዊ ግንኙነት ዙሪያ ከቤተሰቦችህ/ሽ ጋር ግልጽ ውይይት እንዳታደርግ/ጊ የሚያግዱ ምክንያቶች ምንድን ናቸው**?

1.**በወላጆችና ልጆች መካከል መፈራራት ስላለ**

2.**በቤተሰብ መካከል ስለጾታዊ ግንኙነት መነጋገር ልጆችን ወደ መጥፎ ተግባራት ይመራል ተብሎ ስለሚታሰብ**

3.**ሃማኖታችን ስለማይፈቅድ**

4.**ባህላችን ስለማይፈቅድ**

5.**አስፈላጊ ስላልሆነ**

6.**ሌላ ካለ ይገለፅ**…….

2.30 **በጾታዊ ግንኙነት ዙሪያ በሚደረገው ውይይት የወላጆችህን/ሽንሃሳብና ምክር ትቀበላለህ/ትቀበያለሽ**?

1.**አዎ** 2.**የለም**

2.31 **መልስህ/ሽ አዎ ከሆነ በጾታዊ ግንኙነት ባህሪህ/ሽ ያስከተለው ለውጥ አለ**?

1.**አዎ** 2.**የለም**

2.32 **ከጓደኞችህ/ሽ ወይም እኩዮችህ/ሽ ጋር ስለ ኤች.አይ.ቪ በግልጽ ተወያይታችሁ ታውቃላችሁ**?

1.**አዎ** 2.**የለም**

2.33 መልስህ/ሽ የለም ከሆነ እንዳትወያዩ የሚያግዱ ምክንያቶች ምንድን ናቸዉ?

1.እርስ በራሳችን ስለምንፈራራ 3.አስፈላጊ ስላልሆነ

2.ሰለበሽታዉ እዉቀት ስለሌለን 4.ሌላ ካለ ይገለጽ……

2.34 ከብዙ ሰዎች ጋር ወሲብ የሚፈጽሙ ጓደኞች አሉህ/ሽ?

1.አዎ 2. የለም

2.35 ወሲብ በሚፈጸምበት ጊዜ ኮንዶም መጠቀም እንደማያስፈልግ የሚያስቡ ጓደኞች አሉህ/ሽ?

1.አዎ 2. የለም

2.36 በምሽት ጭፈራ ክለቦች እንድትሳተፍ/ፊ የሚገፋፉ ጓደኞች አሉህ/ሽ?

1.አዎ 2. የለም

2.37 የወንድ ወይም የሴት ጓደኛ እንዲኖርህ/ሽ የሚገፋፉ ጓደኞች አሉህ/ሽ?

1.አዎ 2. የለም

2.38 በትምህርት ቤታችሁ ባለው የጸረ ኤድስ ክለብ ትሳተፋለህ/ትሳተፊያለሽ?

1.አዎ 2.የለም 3.የጸረ ኤድስ ክለብ የለም

2.39 መልስህ/ሽ አዎ ከሆነ ምን አይነት መረጃዎች አግኝተህ ታዉቀለህ?

1.ኤች.አይ.ቪን እንዴት መከላከል እንደሚቻል 2.የኤች.አይ.ቪ በሽታ መተላለፊያ መንገዶች

3.ለኤች.አይ.ቪ ስለሚያጋልጡ በህሪያት 4.ሁሉንም 5.ምንም መረጃ አግኝቼ አላዉቅም

ክፍል ሦስት፡-በጾታዊ ግንኙነት ዙሪያ ያለህ/ሽ ልምድ

ቀጥሎ ለቀረቡት ጥያቄዎች የምትሰጣቸው/ጫቸው ምላሾች ምስጢርነታቸው የተጠበቀ ነው ማንም ሰው ማንነትህን/ሽን ለይቶ ሊያውቅ አይችልም በታማኝነት ትክክለኛውን መረጃ በመስጠት ተባበረን/ሪን

3.1 **የግብረ ሥጋ ግንኙነት ፈጽመህ/ሽ ታውቃለህ/ታዉቂያለሽ**;

1.**አዎ** 2.**የለም**

መልስህ/ሽ የለም ከሆነ ወደ ክፍል አራት፡- እለፍ/ፊ

3.2 **መልስህ/ሽ አዎ ከሆነ መቼ ነበር የመጀመሪያውን ግብረሥጋ ግንኙነት የፈጸምከው/ሽው**;

ዕድሜ……

ክፍል 1.**መለስተኛ ሁለተኛ ደረጃ ት/ቤት** (7-8)

2. **ከፍተኛ ሁለተኛ ደረጃ**(9-10)

3. **መሰናዶ** (11-12)

3.3 **ከማን ጋር ነው ብዙዉን ጊዜ የግብረ ሥጋ ግንኙነት የምትፈጽመው/ሚው**;

1.**በቋሚነት ከአንድ ሰው ጋር**

2.**በአጋጣሚ ከማገኛቸው ሰዎች ጋር**

3.**ከሌሎች ብዙ ሰዎች ጋር የግብረ ሥጋ ግንኙነት ከሚፈጽም ሰው ጋር**

4.**ከእኔ እድሜ ከምትበልጥ/ከሚበልጥ ሰው ጋር**

5.ሌላ ካለ ይገለፅ……

3.4 የግብረ ሥጋ ግንኙነት የምትፈጽምበት /ሚበት ምክንያት

1.ፍቅርን ለመግለጽ

2.ጥሩ ውጤት ለማግኘት

3. ጥቅማ ጥቅሞችን ለማግኘት

4.በጓደኞች ግፊት

5. ገንዘብ ለማግኘት

6.ከጭንቀት ለመላቀቅ 7.ተገድጄ 8.ሌላ ካለ ይገለጽ……

3.5 ከስንት ሰው ጋር ነው የግብረ ሥጋ ግንኙነት የምትፈጽመው/የምትፈጽሚዉ;

1.ከአንድ 2.ሁለት 3.ሶስት 4.ከአራት በላይ

3.6 የትኛውን አይነት የግብረ ሥጋ ግንኙነት ነው ብዙዉን ጊዜ የምትፈጽመዉ/ሚው;

1.ወንድና ሴት 2.ሴት ከሴት ጋር 3.ወንድ ከወንድ ጋር 4.1እና 2 5.1እና 3

3.7 የግብረ ስጋ ግንኙነት ለመፈፀም ምን ዓይነት መንገዶችን ነው የምትጠቀመው;

1.በአፍ የሚደረግ ግንኙነት 2.በፊንጥጣ 3.በሴት ብልት ውስጥ 4.ሁሉንም

3.8 ምን ያህል ጊዜ ነው ኮንዶም የምትጠቀመው;

1.አልፎ አልፎ 2.ሁል ጊዜ 3.ብዙዉን ጊዜ 4.ተጠቅሜ አላውቅም

3.9 በሕይወት ዘመንህ/ሽ በግብረ ስጋ ግንኙነት አማካኝነት የሚተላለፉ በሽታዎች /የአባለዘር በሽታዎች ይዘዉህ ያውቃሉ; (የበሽታ ምልክቶቹ የብልት አካባቢ መቁሰልና ሽታ ያለው ፈሳሽ ከብልት ጫፍ መውጣት ሊሆኑ ይችላሉ።)

1.አዎ 2.የለም

3.10. መልሱ አዎ ከሆነ ከየት ነበር ህክምና ያገኘኸው;

1. ከህብረተሰብ ጤና ተቋም 2.ከግል ክሊኒክ 3.ከግል ፋርማሲ 4.በራሱ ጊዜ ዳነ

5. የባህል ህክምና /መድሃኒት ተጠቅሜ 6. በጸበል

ክፍል አራት፡- የተለያዩ እያችን በመጠቀም ዙሪያ ያለህ/ሽ ልምድና የመዝናኛ ጊዜ አጠቃቀምህን በተመለከተ

4.1 አልኮል የመጠጣት ልምድ አለህ/ሽ;

1.አዎ 2.የለም

መልስህ/ሽ የለም ከሆነ ወደ ጥያቄ 4.5 እለፍ/ፊ

4.2 ምልስህ/ሽ አዎ ከሆነ ምን ያህል ጊዜ ነው አልኮል የምትጠጣው

1. ሁል ጊዜ 2.ብዙዉን ጊዜ 3. አንዳንዴ 4.በጣም ጥቂት ጊዜ

4.3 ወዲያው አልኮል ከጠጣህ/ሽ በኋላ የግብረ ሥጋ ግንኙነት ፈጽመህ/ሽ ታዉቃለህ/ታውቂያለሽ;

1.አዎ 2.የለም

4.4 መልሱ አዎ ከሆነ ምን ያህል ጊዜ ኮንዶም ተጠቅመህ/ሽ ታዉቃለህ/ታዉቂያለሽ;

1. **ሁል ጊዜ** 2.**ብዙውን ጊዜ** 3. **አንዳንዴ** 4.**በጣም ጥቂት ጊዜ**

4.5 **ጫት ቅመህ ታውቃለህ/ ታውቂያለሽ**;

1.**አዎ** 2.**የለም**

መልስህ/ሽ የለም ከሆነ ወደ ጥያቄ ቁጥር 4.9 **እለፍ/ፊ**

4.6 **መልስህ/ሽ አዎ ከሆነ ምን ያህል ጊዜ ነዉ ቅመህ/ሽ የምታዉቀዉ/የምታዉቂዉ**;

1. **ሁል ጊዜ** 2.**ብዙውን ጊዜ** 3. **አንዳንዴ** 4.**በጣም ጥቂት ጊዜ**

4.7 **ጫት ከቃምህ/ ከቃምሽ በኋላ የግብረ ሥጋ ግንኙነት ፈጽመህ/ሽ ታዉቃለህ/ታውቂያለሽ**;

1.**አዎ** 2.**የለም**

4.8 **መልስህ/ሽ አዎ ከሆነ ምን ያህል ጊዜ ኮንዶም ተጠቅመሃል/ሻል**;

1. **ሁል ጊዜ** 2.**ብዙውን ጊዜ** 3. **አንዳንዴ** 4.**በጣም ጥቂት ጊዜ**

4.9 **ሲጋራ ታጨሳለህ**;

1.**አዎ** 2.**የለም**

4.10 **ፊልሞችን ተመልክተህ/ሽ ታውቃለህ/ታዉቂያለሽ**;

1.**አዎ** 2.**የለም**

4.11**መልስህ/ሽ አዎ ከሆነ ምን ዓይነት ፊልሞችን ነው አዘዉትረህ የምትመለከተው/የምትመለከችዉ**;

1.**የፍቅር ታሪክ እና የወሲብ ፊልሞችን** 2.**አስቂኝ /የቀልድ እና የወሲብ ፊልሞችን**

3.**የወሲብ ፊልሞች** 4.**ታሪካዊ ይዘት ያላቸው ፊልሞችን** 5.**ሌላ ካለ ይገለጽ**……

4.12 **ፊልሞቹን ከተመለከትህ/ሽ በኃላ ምን ታደርጋለህ/ሽ**;

1.**አልኮል እጠጣለሁ** 2.**ወሲብ የመፈጸም ፍላጎት ይኖረኛል** 3.**ወሲብ እፈጽማለሁ**

4.**እንዲሁ እዝናናለሁ**

4.13 **በምሽት ጭፈራ ክለቦች ተሳትፈህ ታዉቃለህ/ታዉቂያለሽ**;

1.**አዎ** 2.**የለም**

4.14 **ቀጥሎ ከተዘረዘሩት ዕፆች የትኞቹን ተጠቅመህ ታውቃለህ/ሽ**;

1.**ሽሻ** 2.**ሀሽሽ** 3.**አደንዛዥ ዕፅ** 4.**ምንም ተጠቅሜ አላውቅም**

5.**ሁሉንም ተጠቅሚያለሁ** 6.**ሌላ ካለ ይገለጽ**…….

በዚህ ጥናት ለመሳተፍ ፍቃደኛ ስለሆንክ/ሽ ከልብ አመሰግናለሁ!!!

Annex3: Declaration

I, the undersigned declare that this thesis is my original work in partial fulfillment of the requirement for the degree of Master of Public Health. I also declare that it has never been presented in this or any other university and that all resources and materials used in the thesis have been duly acknowledged.

Student Name: _____

Signature: _____ _____

Place of submission: _____

Date of submission: _____

This thesis has been submitted for examination with my approval as a university advisor.

Advisor Name: _____

Signature: _____ _____

Date of submission: _____